

**The Wisconsin Partnership Program
Financial Issues Outline
for the
Robert Wood Johnson Foundation**

The following is a summary of Financial Issues important in creating and operating a special managed care program like the Wisconsin Partnership Program. The issues outlined below were extracted from the WI Partnership Program Protocols, the Department of Health and Family Services contract with the partnership organizations, the Partnership Program rate reports, and information from Partnership Program organization financial directors Larry Paplam and Tom Hanks, Partnership Program Manager David Sievert and Partnership staff Steve Landkamer and Ann Pooler.

FINANCIAL GOALS OF THE WPP:

To move from paying health claims to purchasing high quality health and long-term care services for a population that is frail elderly or physically disabled.

To protect and improve the health and satisfaction of beneficiaries.

To develop and implement a strategy to buy quality health care services that gives value for the dollar to beneficiaries and purchasers.

To enhance performance and accountability in a quality health and long-term care delivery system that is affordable, effective, safe, protecting, and improving enrollee health and satisfaction and that responds to specific health and long-term care needs of individuals who are frail elderly or who have a physical disability.

2) MANAGED CARE ENVIRONMENT:

The Wisconsin Partnership Provider (WPP) operates in a managed care environment. This requires:

- A working partnership between the State Government, the Federal Government and the individual sites
- A capitation reimbursement mechanism for acute and primary long-term care services
- A voluntary program.
- That the Medicaid capitation can not exceed the Upper Payment Limit restrictions imposed by Federal regulation on Medicaid managed care programs (The managed care organization cannot exceed the cost of delivering the same set of services to a comparable population in a fee for service (FFS) environment)

3) **STARTUP CONSIDERATIONS**

- Conduct a feasibility study:
 - Determine the potential market
 - Determine how the service capacity could be developed to operate the program
 - Determine the financial implications to develop and operate the program
 - Evaluate the health-related services (and social and other support services) needs necessary for improving the population's health
 - Develop an epidemiological-oriented profile of the health and service needs of the elderly and physically disabled population in the counties to be served based on assessments of:
 - the incidence and prevalence of medical conditions within the community
 - the social and demographic features associated with Medicaid eligibility access and use of primary and specialty services;
 - Survey the provider community support:
 - Identify the support available in the provider community. (State and local public agencies, advocacy groups, consumers, providers, and MCOs.)
 - Identify existing funds and structures to develop purchasing specifications and delivery systems contracts to create a value-based and cost-effective system of care for elderly and physically disabled systems of care; and
 - work with stakeholder groups to improve the quality of care for the populations: identify goals, review interventions and oversight mechanisms, identify health care outcome measures and assess tools
- Account for current resources (financial and personnel). Evaluate what's available and what additional resources are necessary.
- Determine what to contract for in assessing the contracted benefit package. (What is included in a full-risk contract?)
- Determine benefits to be covered: Identify where Medicaid benefits end and where other system of care, i.e. Medicare and other State and local funding sources begin to assure coverage across the continuum of care.
- Determine data to be collected
- Track patterns of health service use, under utilization
- Develop the rate capitation method:
 - The methodology needs to assure adequate payments for the targeted population. The rates need to reflect that resource use for the frail elderly and the physically disabled differ from the general population. Providers should not be at undue risk for caring for the population.
- The Federal Government requires the rates to be computed on an actuarially sound basis. Rates may not exceed the cost of providing the contracted services on a fee-for-service basis to an actuarially equivalent non-enrolled population group.
- Evaluate financial incentives to providers and MCOs to encourage appropriate delivery of care to the frail elderly and physically disabled.

4) **CAPITATION METHODOLOGY:**

The WPP operates under a Dual Waiver approved October 16, 1998 by the Health Care Financing Administration. Under the dual waiver a per member per month (PMPM) payment is made from both the Wisconsin Medical assistance program, the State administered Medicaid health care program for financially needy aged, blind and disabled people and from Medicare, the Federal health care program for the elderly and for people with disabilities.

- **Medicaid PMPM**

Three years of State historical paid Medicaid claims nursing home data for the physically disabled population and the elderly population are used as the basis for calculating the per member per month (PMPM) rates that the MA program will pay to service a similar population in the community. The sites' actual level of care mix, the sites' MA and Dual eligibility and their age cohort adjust the rates. Paid claims data is used to represent cost data. It is net of third party liability, patient liability, Medicare and other payment sources. High cost data for recipients paid outside the capitation rate are excluded.

The cost data is adjusted to account for the billing lag, inpatient hospital adjustments, trend factors and administrative costs. A discount is taken from the equivalent fee-for-service net Medicaid expenditure amounts.

- **Medicare PMPM**

The Medicare PMPM is equal to the Wisconsin geographical average adjusted per capita cost (AAPCC) rate times the 2.39 adjustment factor.

- **Payments**

The Medicaid program makes payments to the sites based on enrollment reports. The capitation payments are payments in full. The site does not bill, charge, collect or receive any other form of payment from the DHFS except as permitted by Medicaid regulations and agreements with the DHFS.

- **Site Responsibilities**

- Sites agree not to bill a member for medically necessary services covered under the contract.
- Sites agree to pay all contract services provided to all recipients
- The sites are responsible to pursue, collect and retain any monies from third party payers (TPL) for services to enrollees covered by other insurance parties. The sites must attempt to collect TPL before claiming reimbursement from DHFS. TPL includes subrogation collections arising out of settlement of personal injury, medical malpractice, and product liability or worker's compensation.
- The sites agree to pay at least 90% of adjudicated claims from subcontractors for covered medically necessary services within 30 days of receipt of bill and 99% within 90 days
- The sites agree to not bill the enrollees.
- Members enrolled in WPP sites are not liable for the debts of the site or its subcontractors in cases of site or subcontractor insolvency.

5) RECOUPMENTS

The DHFS and HCFA reserve the right to recoup capitation payments in the following situations:

- When payments are made for health care services provided by non-certified providers, at the fee-for-service rate for those services.
- When payments are made after a change in a participant's status (member moves out of service area, member enters a public institution, member dies.)
- To correct an error
- As a relief mechanism to backfill losses incurred by the site
- To terminate the contract
- As a sanction to a site for committing a federal violation.

6) START UP COSTS/START UP FUNDS

- **Planning**
 - You need a sound business plan
 - See APPENDIX
- **Capital**
 - Enough Capital is needed to reach the break even point
 - Capital is needed to cover Start-Up Operating expenses
 - Keep track of net cash inflow after liabilities
 - Do not count on funds unless they are committed funds
 - Fund sources may dictate what may be financed, and how much debt may be assumed

7) SOURCES OF FUNDS

- Internal Funds (Gift, versus Loan, versus Sweetheart deal)
- Outside Grants, Gifts and Fund Raising
- Bond Issues (Government subsidized versus private placement)
- Mortgages (Conventional, balloon, etc.)
- Line of Credit (Short-term needs only)
- Other

8) OPERATIONAL AND MANAGEMENT ISSUES

- **Manage Growth:**
 - Too little growth is reason for failure
 - Too much growth can destroy system
 - Ensure that quality staff are employed and that adequate staff are hired
 - Prevent over scheduling staff
 - Develop a plan to deal with rapid growth? Develop a plan of delegation?
 - Do not outstrip management, financial or system capabilities
 - Assure that an adequate number of providers are available to care for the elderly and physically disabled population
 - Market the program to beneficiaries through active outreach, and through the education of the public and providers
- **Manage Membership:**
 - Are you paying for non-members?
 - Track eligibility to ensure that members are Medicaid and/or Medicare eligible
- **Manage Cost:**
 - Under the capitation system evaluate costs in a per member per month basis
- See **APPENDIX**, Resource Allocation Decision Method

9) OPERATIONALIZE BUSINESS LIFE CYCLE:

- Live by statistics (Utilization based upon regression) (the law of large numbers will not work, the sample is too small)
- A sites five main regression variables:
 - # of normal business days per month (varies from 20 - 23)
 - # of capitated clients (cash inflows/outflows)
 - # Adult home care visits (staffing/ancillary utilization, vans, labs)
 - # Inpatient hospital admissions (limit by per diem contract if possible)
 - # Nursing and Group Home occupancy from month to month
- Make trends and comparisons (13-month roll)
- Evaluate how expense distribution changes over time
- Make comparisons by location within the program
- Prepare quarterly trend reports
- Prepare comparative annual reports
- Make peer Comparisons
- Watch out for expensive costs (outliers)

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- Account for time requirements to file and adjust claims
- Integrate authority and tracking systems between the clinical and the financial systems

10) REPORTING FOR ANALYSIS

- Report on a Per Member Per Month (PMPM) basis: i.e. individual department expenses divided by number of clients
- Report as a percent of capitated revenue, i.e. individual department expenses divided by gross capitated revenue
- Report on per business day
- Report what is needed for management
- Track incurred but not reported (IBNR) expenses

IBNR = incurred but not reported expenses. It is an estimation of costs for services provided to clients, but for which you have not yet received bills. For example: if you know that you had ten inpatient admissions in a given month but have received only six bills, you need to estimate the cost of the other four bills. The estimate is charged to IBNR as an expense for that month, and that month's IBNR is reduced by the actual amount of the bills when they are received. IBNR provides proper matching of expense with revenue.

- Track how quickly bills for service are received, approved and posted. (Like Accounts Receivable Aging) Reports are affected by Time of Year, # processing staff, authorization process, end of month closer.

11) RISK MANAGEMENT:

Contracts, sub-capitation, re-insurance, outlier protections (Ventilator FFS), Carveout, Retrospective Adjustments, Risk Reserves, Other Solvency tools, and Risk Sharing Arrangements.

- **CONTRACTS:**
 - Benefit Continuations;
 - Hold Harmless Provisions: Fed, State, Members
 - Time Limit on Claims
 - Authorization Process
 - Define Services & Charges
 - Performance based contracts
 - Watch out for fraud and abuse
 - Physicians are cautioned in the Fraud Alert (1) not to prescribe services and items as a courtesy to a patient, service provider, or medical equipment supplier, without first making a determination of medical necessity, (2) not to knowingly or recklessly sign false or misleading medical certifications, and (3) not to accept kickbacks in return for their signature.

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- **SUB-CAPITATION**
 - Shift and limit financial risk
 - Even cash flow
 - Risks require monitoring that services sub contracted or capitated are delivered
 - If considered insurance, does it meet with state law

- **RE-INSURANCE**
 - Re-insurance is used to guard financial exposure.
 - It is expensive and difficult to obtain

- **OUTLIER PROTECTION**
 - State Medicaid determines outlier policy for high cost. The costs of providing Medicaid covered services to enrollees who are ventilator assisted patients, who have a confirmed diagnosis of AIDS or are HIV positive are covered. The providers report the costs and reimbursement is based on actual costs, not limited to the capitation.
 - People diagnosed as ESRD prior to enrollment under the Medicare capitation may not be enrolled and are excluded by Medicaid/Medicare from the capitation mechanism, however if an enrolled Medicaid/Medicare individual becomes ESRD after enrollment they may remain in the program.
 - A special capitation rate is calculated for individuals who qualify for the Intensive skilled nursing level of care as determined by the Wisconsin Bureau of Quality Assurance.
 - Services may be carved out or excluded from contract. Under the dual waiver the WPP sites operate at full risk for all medical services except the outlier cases indicated.

- **RETROSPECTIVE RISK ADJUSTMENTS**

Retrospective ("reality") adjustments:
Are made at year-end to correct the projected capitation rate based on actual enrollment. The actual experience is carried over in the projections of the mix for the following year.
The department makes retrospective payment adjustments for:

 - Age Mix: The actual enrollment months by age cohort does not match the projected enrollment by age cohort used for rate setting purposes.
 - Level of Care: The actual nursing home level of care distribution does not match the projected nursing home level of care distribution used for rate-setting purposes.
 - MA/Dual: The proportion of enrollees who are dually eligible for both Medicare and Medicaid coverage does not match the projected distribution of Medicare and/or Medicaid eligibles for rate setting purposes.

- **RISK RESERVE**

The risk reserve is a cash equivalent safety net to pay for continued provision of services in an insolvent program. The purpose of the risk reserve is:

- To provide and ensure continuity of care for enrolled members
- To provide solvency protection against financially catastrophic cases
- To ensure effective program management
- To ensure accountability to taxpayers
- To provide cash to weather adverse incidents

Characteristics of risk reserve:

- Separate Fund. Segregation of the risk reserve fund is required. It can not be intermingled with other funds of the organization.
- Restricted to use
- Unencumbered (not used as collateral)
- Composed of Cash and Cash equivalents (marketable securities, readily convertible into cash). A separate depository or investment account is established for the risk reserve fund.
- Conservatively invested (i.e.: 65% Triple A Bonds)
- Maintained by independent outside institution that is State or Federally licensed or chartered and is in good standing.
- Periodically Monitored (Finance Committee monthly meetings). Deposits and withdrawals are to be accounted for and documented.
- Last resort usage
- Usage may be restricted to a % of balance
- Must have a written insolvency protection plan

- **RISK RESERVE CONTRIBUTION**

- Evaluate where exposure is:
- Manage the number of inpatient admissions, reinsurance, per diem versus DRG payment, sub capitation
- Funding: Initial Contribution (1 or 2 months expenses) or periodic
- Reinvest the earnings
- How much is too much
- Initially, a higher percentage of income is required for the risk reserve

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- With growth, the rate slacks off
 - Members become increasingly expensive so a risk reserve is needed
 - New members bring new money
 - New members are less costly
 - Develop a risk reserve PMPM contribution
 - Develop a required contribution based on the number of clients
 - Set up the PMPM contribution as a multiple of the cap rate
 - The risk reserve can be developed as a % of revenue
 - The % of contribution is from 5-17% (based on .6-2 months of revenue)
 - WPP requires that sites agree to establish and maintain a risk reserve fund equal to the initial contribution. Within 30 days following program start-up the risk reserve account amount must equal 50% of the projected revenues to be received on enrollees funded by WI Medicaid for the first three calendar months.
 - Monthly Contribution. Sites deposit monthly an amount equal to 5% of revenue received for WI Medicaid enrollees during the prior month up to the required minimum balance
 - Earnings. Interest income or gains generated by risk reserve fund (RRF) remain in account
 - The required minimum balance of the Medicaid RRF is \$325,000
 - The required minimum balance of the Medicare RRF is two months of Medicare capitation per Medicare member
 - At each calendar year end (CYE) the unspent excess Medicaid revenues are deposited into the RRF to the required minimum balance.
- **DISBURSEMENTS**
 - Disbursements and Minimum Reserves. Disbursements may be made from the risk reserve for operating deficits for payments to the DHFS required under the contract. If any disbursement causes the risk reserve to be reduced temporarily below the minimum level specified in the contract, the site, within 30 days of the relevant disbursement, must submit a plan for DHFS approval that specifies the methods and timetable the site will employ to reestablish minimum risk reserves. Failure to submit an acceptable plan to the DHFS may subject the site to sanctions specified in the contract. Generally, the DHFS will expect the minimum reserves to be reestablished within six months. The contractor will seek payment in the following order:
 - Stop loss/reinsurance
 - Risk reserve funds
 - Risk sharing arrangements
 - Disbursement limit: Disbursements will be discontinued when the risk reserve fund balance is 25% of required minimum balance

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- Member protection: Members are not liable for the WPP debt. Members will be returned to MA and/or MC FFS or other insurance programs
- The WPP will meet the financial and enrollment reporting requirements of the Office of the Commissioner of Insurance (OCI)
- The risk capitated basis is subject to the insurance requirements of the State Statutes, or an exemption from the insurance requirements is required
- **EXEMPTIONS**
Exemptions require financial and enrollment reporting to OCI including:
 - A balance sheet reporting the assets/liabilities
 - A revenue/expense statement
 - An enrollment table with enrollees by quarters
 - An annual financial audits
 - Sanctions from HCFA/or the Medicaid Agency may be imposed for non-compliance with OCI, Medicare/Medicaid rules and include:
 - Denial of capitation payments
 - Suspension of enrollment
- **OTHER SOLVENCY TOOLS**
 - Lines of credit (short-term) for loans
 - Parent organization support
 - Capital Aggregate (Re) Insurance & Insolvency Insurance- expensive, 5-9% of coverage, guarantees coverage if CMO becomes insolvent
 - NET Assets: longer term, based on strength of the balance sheet
- **RISK SHARING**
 - States are subject to Upper Payment Limit (Rates do not exceed 95% of the nursing home rate)
 - Based on whether the organization shows a profit or loss, not on their cash flow
 - Phased out over time usually
 - Protects against startup costs
 - Protects against variability in initial rate setting
 - Types of risk sharing arrangements include:
 - Sharing gains/losses symmetrically or asymmetrically

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- Varying how gains and losses are shared: based on their level, regardless of \$ or %
- Stratified risk sharing based on changing %
- Varying methods of handling losses

12) FEDERAL SOLVENCY PROTECTION

- Protect enrollees by carrying liability protection
- Establish contractual arrangements that prohibit health care providers from holding any enrollee liable
- Carry insurance (must be HCFA acceptable)
- Maintain financial reserves (HCFA acceptable)
- Develop an insolvency plan to protect against loss of benefits if the WPP becomes insolvent
- Keep in place for the duration of the contract period for which payment made
- Consider reinsurance or other protection for enrollees who are inpatient until discharged
- Maintain a Federally fiscally sound operation
- Maintain a Current Asset Ratio: Total Assets greater than liabilities
- Maintain sufficient cash flow and liquidity to meet due obligations
- Maintain a net operating surplus or a financial plan (Marketing, Statement of Revenue and Expenses on an accrual basis, Sources, Uses, Balance Sheet)
- Maintain an insolvency protection plan
- Fidelity bond covering officer and employee

13) FEDERAL INSOLVENCY PROTECTION

- 2 months of uncovered Medical expenditures
- reduce by insolvency insurance
- hold harmless contracts
- continuation of benefit provisions
- Letters of credit
- Restricted reserves
- Other guarantees
- Adjusted net assets

14) ANNUAL AUDIT:

- Letters to Management performed by CPA
- Financial statements show financial position of WPP in each enrollment area

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- Total costs, direct and indirect related to enrollees
- Estimates based on Generally Accepted Accounting Principles (GAAP)
- Access to records must be provided to HCFA/Medicaid
- Records Retention
- Special reporting and compliance

15) **BUDGET NEUTRALITY**

• **RESEARCH and DEMONSTRATION WAIVERS**

- Under 1115 Waivers: States can deviate from standard Medicaid requirements in order to test new ideas of policy merit and to enact initiatives such as:
 - Small-scale pilot projects testing new benefits or
 - projects to test financing mechanisms
 - restructuring State Medicaid programs
 - welfare reform projects

- **BUDGET NEUTRALITY** Programs cannot cost more *over their duration* than the Medicaid program would have spent in the absence of the demonstration

- Calculations: WPP Budget Neutrality is based on the Per Capita Cost Method
- The Per Capita Cost Method = Limit on Title XIX funding the State may receive in WPP 1115 Waiver
WI is at risk for Medicaid per capita cost of Medicaid recipients and dual eligibles but not at risk for the number of eligibles (This is to ensure HCFA that the demonstration Medicaid expenditures do not exceed the levels of spending that would have been realized had there been no demonstration.)
- Budget Neutrality includes the calculation of the YEARLY BUDGET LIMIT =
Sum of the cost projection for dual eligibles and Non-dual eligible cost projections calculated above.
- **MEDICAID BUDGET NEUTRALITY RECONCILIATION PROCESS FOR WPP**
 - The WPP's budget neutrality is reviewed on an annual basis
 - Final reconciliation will be based on the average budget discrepancy accrued during the 5-year demonstration period.
 - At end of demonstration: If the budget neutrality provision is exceeded, any excess Federal funds are returned to HCFA

APPENDIX 1 - START UP Costs

August 16, 1999

TO: Ms. Patty Schultz
FROM: Tom Hankes, Community Health Partnership, Inc.

SUBJECT: Community Health Partnership, Inc. Start Up Funding

Narrative Explanation

The attached worksheet provides a simplified yet valid approach to estimating the extra expenses incurred by CHP due to the low volume of members in the early months of the partnership program.

For purposes of this discussion, I'll assume there are 3 types of costs involved in running the partnership program:

- Directly variable costs - costs that increase (or decrease) in direct proportion to the number of members in the program. An example would be drug expenses.
- Step costs - Costs that are somewhat related to volume, but occur in discrete steps. An example might be the additional rent due to expansion. A facility might get along fine with 5000 square feet, but when team 5 needs to be added, it creates an over crowding situation.
- Fixed costs - costs which are unrelated to volume. An example of this might be the salary of a manager.

It assumes that certain costs per member per month (PMPM) are much higher in the early phases of the program than in the later stages when the program will reach full capacity.

For example, Let's assume the salaries of one of the teams comes to \$150,000 on an annualized basis. Assume also that this team begins with 10 members and over a 12 month period builds up to 50 members. The monthly salary initially comes to \$1,250 PMPM (\$150,000/12/10 members). The monthly salary initially comes to \$250 PMPM (\$150,000/12/50 members). Therefore, the amount due to low capacity could be calculated to be \$1,250 - \$250 or \$1,000 PMPM.

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This is the thinking behind this document. We could have listed each account or expenditure individually, but that would have created a very lengthy document and perhaps caused more confusion than this abbreviated one.

Terms/Definitions

CHP Support - Salaries and benefits of the care teams that provide member services

General & Administrative costs - Examples include expenses such as salaries and benefits of people who provide office support to the CHP care teams, copy machines, office supplies, rent and so on.

Member - A enrollee in the Community Health Partnership, Inc. program who may be either disabled or a frail elderly person.

Start up costs - Those expenses that are required regardless of the number of enrollees. A good example would be management salaries.

PMPM - An acronym for "Per member per month"

Member month - This can be thought of a volume or quantity measurement. Assume that two members are enrolled for 6 months. This would equate to 12 "member months"

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Community Health Partnership, Inc.

Start up funding
FY 1999 Only

| | | <u>FY 99 Actual to 5/99</u> | <u>6/99 to 12/99 Projected</u> | <u>FY 99 Total</u> |
|--|------|---------------------------------|------------------------------------|------------------------|
| CHP | | 197,874 | 294,942 | 492,816 |
| Support | | | | |
| General & | | 384,115 | 589,245 | 973,360 |
| Administrative | | | | |
| Equipment | | 12,678 | 0 | 12,678 |
| * | | | | |
| Totals | (a) | 594,667 | 884,187 | 1,478,854 |
| Number of calendar months in period | | 5 | 7 | 12 |
| Total members at full enrollment | 300 | | | |
| Total "member months" at full enrollment | (b) | 1,500 | 2,100 | 3,600 |
| Start up costs PMPM at full enrollment (a)/(b) | | 396.44 | 421.04 | 410.79 |
| Actual and budgeted "member months" | (c) | 687 | 1,321 | 2,008 |
| Start up costs PMPM at current enrollment (a)/(c) | (d) | 865.60 | 669.33 | 736.48 |
| Cost difference PMPM due to low volume at start up | (e) | 469.15 | 248.29 | 325.69 |
| --- (d) less (b) | | | | |
| Calculated start up costs due to low enrollment | | 322,309 | 327,991 | 653,982 |
| Projected "member months" to 12/31/99 X | | | | |
| Cost difference (e) X | | | | |

(c)
* Primarily Computer equipment

APPENDIX 2- ADJUSTMENTS

The following tables illustrate the adjustments applied to two of the WPP organizations over the last two years. The first set of 4 tables show the 1997 and 1998 projected and actual age distributions along with the fiscal outcomes at Org A of Dane County (Org A) and Org B (ORG B).

| Org A of County 1997 | | | |
|----------------------|-------------------------|--------|--------------------------------|
| | Enrollment Distribution | | Net (Under Pmt) Over Pmt |
| Age Cohort | Assumed | Actual | |
| 55 - 64 | 7.0% | 14.9% | |
| 65 - 74 | 31.0% | 33.8% | |
| 75 - 84 | 39.0% | 32.6% | |
| 85 - 94 | 21.0% | 18.4% | |
| 95 + | 0.0% | .03% | |
| Total | 100.0% | 100.0% | \$ (213,123) |

| Org A of County 1998 | | | |
|----------------------|-------------------------|--------|--------------------------------|
| | Enrollment Distribution | | Net (Under Pmt) Over Pmt |
| Age Cohort | Assumed | Actual | |
| 55 - 64 | 15.5% | 13.5% | |
| 65 - 74 | 31.5% | 33.3% | |
| 75 - 84 | 34.0% | 31.4% | |
| 85 - 94 | 19.0% | 20.5% | |
| 95 + | 0.0% | 1.4% | |
| Total | 100.0% | 100.0% | \$ 24,915 |

| Org B of County 1997 | | | |
|----------------------|-------------------------|--------|--------------------------------|
| | Enrollment Distribution | | Net (Under Pmt) Over Pmt |
| Age Cohort | Assumed | Actual | |
| 55 - 64 | 2.0% | 1.9% | |
| 65 - 74 | 20.0% | 21.3% | |
| 75 - 84 | 39.0% | 38.7% | |
| 85 - 94 | 33.0% | 32.7% | |
| 95 + | 6.0% | 15.4% | |

| Org B of County 1998 | | | |
|----------------------|-------------------------|--------|--------------------------------|
| | Enrollment Distribution | | Net (Under Pmt) Over Pmt |
| Age Cohort | Assumed | Actual | |
| 55 - 64 | 2.0% | 4.1% | |
| 65 - 74 | 20.0% | 24.4% | |
| 75 - 84 | 39.0% | 36.6% | |
| 85 - 94 | 33.0% | 29.0% | |
| 95 + | 6.0% | 5.9% | |

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| | | | |
|-------|--------|--------|-------------|
| Total | 100.0% | 100.0% | \$ (16,143) |
|-------|--------|--------|-------------|

| | | | |
|-------|--------|--------|-------------|
| Total | 100.0% | 100.0% | \$ (65,273) |
|-------|--------|--------|-------------|

The following tables show the projected Level of Care (LOC) distribution along with the fiscal outcomes.

| Org A of County 1997 | | | |
|----------------------|-------------------------|--------|--------------------------------|
| | Enrollment Distribution | | Net (Under Pmt) Over Pmt |
| LOC | Assumed | Actual | |
| ICF | 30.4% | 44.0% | |
| SNF | 69.6% | 56.0% | |
| Total | 100.0% | 100.0% | \$ 96,277 |

| Org A of County 1998 | | | |
|----------------------|-------------------------|--------|--------------------------------|
| | Enrollment Distribution | | Net (Under Pmt) Over Pmt |
| LOC | Assumed | Actual | |
| ICF | 44.5% | NA | |
| SNF | 55.5% | NA | |
| Total | 100.0% | 100.0% | 0 |

| Org B of County 1997 | | | |
|----------------------|-------------------------|--------|--------------------------------|
| | Enrollment Distribution | | Net (Under Pmt) Over Pmt |
| LOC | Assumed | Actual | |
| ICF | 50.0% | 44.0% | |
| SNF | 50.0% | 56.0% | |
| Total | 100.0% | 100.0% | \$ (182,289) |

| Org B of County 1998 | | | |
|----------------------|-------------------------|--------|--------------------------------|
| | Enrollment Distribution | | Net (Under Pmt) Over Pmt |
| LOC | Assumed | Actual | |
| ICF | 49.0% | NA | |
| SNF | 51.0% | NA | |
| Total | 100.0% | 100.0% | 0 |

1) The 1998 LOC adjustment has not yet been completed.

- In the first set of 4 tables, both sites received retrospective adjustments because they served age cohorts that differed significantly from the projected enrollment. The enrollees served by Org A had an age mix that was more expensive to serve. Org A, therefore, received an upward adjustment, a fiscal consideration for adverse selection. ORG B served an age mix that was less expensive to serve. ORG B, therefore, received a downward adjustment. Value purchasing was assured.
- In the second set of 4 tables, both organizations received adjustments based on the LOC mix of their respective enrollees. Org A served a population with a lower than projected LOC mix and, therefore, was asked to repay some of the capitation received. ORG B served a population with a higher than expected LOC mix. They received an upward adjustment, a fiscal consideration for adverse selection.